DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/27/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15C0001105	B. WING				C / 16/2015	
NAME OF PROVIDER OR SUPPLIER SOUTH EMERSON SURGERY CENTER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 8141 S EMERSON AVE STE C INDIANAPOLIS, IN 46237			710/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
Q 000	INITIAL COMMENTS	3	Q	000				
	This visit was for the complaint.	e investigation of 1 Federal						
	Complaint: IN00167 Substantiated, Feder allegation are cited.	992 ral deficiencies related to						
	Date of Survey: 3/16	6/15						
	Facility number: 002	2837						
Q 041	QA: cjl 03/20/15 416.41(a) CONTRAC	CT SERVICES	Q	041				
	with an outside resor	rovided through a contract urce, the ASC must assure re provided in a safe and						
	Based on interview,	not met as evidenced by: the facility failed to ensure yed orientation for 2 of 2 staff						
	Findings:							
	Assistant) confirmed of facility #2. On 2/2 come to the facility to he/she was a "gophe operating room and p	5 hours, staff #2 (Medical that he/she is an employee 5/15, he/she was asked to work. He/she indicated that er" for the staff working in the post anesthesia care unit. It this was the only time that it the facility.						
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATU	DE		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		15C0001105	B. WING			C 03/16/2015	
NAME OF PROVIDER OR SUPPLIER SOUTH EMERSON SURGERY CENTER			1	8	TREET ADDRESS, CITY, STATE, ZIP CODE 141 S EMERSON AVE STE C NDIANAPOLIS, IN 46237	1 03/	10/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPOLICIENCY)			(X5) COMPLETION DATE
Q 041	Assistant) confirmed of facility #2. On 2/25 asked to come to the indicated that he/she working in the operation anesthesia care unit. was the only times the facility. 3. Personnel files/orierom staff #1 (Administration 3/16/15 at 1030 he	O hours, staff #4 (Medical that he/she is an employee 5/25 and 3/4/15, he/she was facility to work. He/she was a "gopher" for the staffing room and post He/she indicated that this at he/she has worked at the entation were requested strator) for staff #2 and #4 burs and none were provided	Q	041			
Q 242	The ASC must mainta designed to prevent, infections and commu addition, the infection program must include ASC has considered,	N CONTROL PROGRAM ain an ongoing program control, and investigate unicable diseases. In	Q	242			
	Based on policy/prodreview and interview, that nursing personne for instrument sterilization for instrument sterilization. Findings: 1. Review of policy/p Logging", last reviewed the following:						

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		15C0001105	B. WING _			C	
NAME OF PROVIDER OR SUPPLIER SOUTH EMERSON SURGERY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8141 S EMERSON AVE STE C INDIANAPOLIS, IN 46237		ı	03/16/2015	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
Q 242	cycle complete are very the compart the compart the compart of the compart of the compart of the compart of the cycles were run on 2000 ATTEST cycle logged review of the computer of the computer of the computer of the cycles frequency is every day. 4. On 3/16/15 at 154 (Administrator) confirmation of the computer of the cycles frequency is every day.	erified and yes is circled on outer printout. name , I.D. number and the personnel's initials will e computer printout if no computer printout is oclave Log indicated that 3 (25/15. There was no don the autoclave log or inter printouts for 2/25/15. for ATTEST cycles testing by that autoclaves are used. 0 hours, staff #1 med that an ATTEST cycle a load is run and 2/25/15 did	Q 2	42			